THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-03-3594.M2

May 12, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0994-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Occupational Medicine. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient injured his low back and left knee at work on ___. An MRI of the lumbar spine on October 20, 1999 showed L4/5 disc protrusion with stenosis at L3/4 and L4/5. An EMG/NCV dated June 13, 2000 showed acute bilateral L4, L5 and S1 radiculopathy. An MRI of the knee of August 15, 2000 showed injury to the lateral meniscus. An arthroscopic left knee lateral meniscectomy and medial femoral chondroplasty were performed by ___. Post-operative notes indicate good healing and resolution of the knee pain.

At the end of May 2002, laminectomy and bilateral foraminotomies L4/5, laminotomy and bilateral foraminotomies L3/4, lateral fusion L4/5 and posterior segmental instrumentation L4/5 were performed. Little discussion regarding the efficacy of the procedure is found in the records, other than to say that the patient continued with sever

low back pain. No records of post-operative rehabilitation or physical therapy were provided for review, but the medical records appear incomplete.

A psychological evaluation dated January 12, 2003 diagnosed atypical depression and psychological disorder associated with a medical condition, recommending enrollment in a multidisciplinary chronic pain program. A treatment plan from Positive Pain Management consisting of thirty days, eight hours per day of physical rehabilitation, individual psychotherapy, group therapy, biofeedback training and medication management has been proposed.

REQUESTED SERVICE

A chronic pain management program is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

A review of the medical literature provides evidence that an intensive multidisciplinary bio-psycho-social rehabilitation program with a goal of functional restoration can improve pain and function in patients with chronic low back pain. Based upon the medical records provided, this patient is physically and psychologically dysfunctional and would likely benefit from such a program as described by Positive Pain Management.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 12th day of May 2003.